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*In The Supreme Court of The United States*

**OCTOBER TERM, 1997**

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No.

JACK ECKERD CORPORATION, PETITIONER

*v.*

THOMAS SHANNON, RESPONDENT.

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**ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT**

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42 pp

## QUESTION PRESENTED FOR REVIEW

WHETHER THE ELEVENTH CIRCUIT ERRED IN AFFIRMING THE DISTRICT COURT, WHICH, AFTER FINDING THAT THE PETITIONER HEALTH BENEFITS PLAN HAD ACTED ARBITRARILY AND CAPRICIOUSLY IN DENYING THE RESPONDENT BENEFITS FOR A PANCREAS TRANSPLANT ON THE GROUNDS THAT THE PROCEDURE WAS EXPERIMENTAL AND/OR INVESTIGATIONAL AND REMANDING THE MATTER TO THE PLAN FOR FURTHER DETERMINATION, ERRED IN DIRECTING THE PLAN ON REMAND TO CONSIDER EVIDENCE AVAILABLE UP TO THE DATE OF ITS DECISION ON REMAND RATHER THAN AT THE TIME THE PLAN MADE ITS ORIGINAL DECISION, SUCH THAT THE ELEVENTH CIRCUIT'S DECISION IS IN CONFLICT WITH THE DECISIONAL LAW OF THE EIGHTH CIRCUIT.

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The Petitioner, JACK ECKERD CORPORATION, petitions this Honorable Court for a writ of certiorari to review a judgment of the United States Court of Appeals for the Eleventh Circuit in this case.

## OPINIONS BELOW

The opinion of the Court of Appeals (App. 20-23) is reported at 113 F.3d 208 (11th Cir. 1997). The decisions and orders of the United States District Court for the Southern District of Florida are not reported (App. 1-19).

## STATEMENT OF JURISDICTION

This Court has jurisdiction of this matter pursuant to 28 U.S.C. § 1254, since it involves review of a Final Judgment of the United States Court of Appeals for the Eleventh Circuit, affirming a judgment of the United States District Court for the Southern District of Florida, based on the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq. The Eleventh Circuit rendered its original judgment on May 29, 1997, and denied Petitioner's Petition for Rehearing and Suggestion of Rehearing *En Banc* on September 4, 1997. The Eleventh Circuit's decision in this case is in direct conflict with the Eighth Circuit Court of Appeals' decisions in *Bernards v. United of Omaha Life Ins. Co.*, 987 F.2d 486 (1993) and *Cox v. Mid-America Dairymen, Inc.*, 965 F.2d 569 (8th Cir. 1992).

## STATUTORY PROVISIONS INVOLVED

Section 1132 (a)(1)(B) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. §1132 (a)(1)(B) provides as follows:

> A civil action may be brought--
>
> (1) by a participant or beneficiary--
>
> (B) to recover benefits due him under the terms of his plan, to

enforce his rights under the terms of the plan, or to clarify his right to future benefits under the terms of the plan;

## STATEMENT OF THE CASE

This action arose out of the denial of Respondent Thomas Shannon's ("Shannon") request for pre-authorization of benefits for the pancreas portion of a simultaneous kidney/pancreas transplant by the employee group health benefits plan of Petitioner (App. 1-2 ). Respondent is a beneficiary of the Jack Eckerd Corporation Health Benefits Plan ("the Plan"), which is a self-funded group employee health benefits plan, an employee welfare plan as defined in ERISA, 29 U.S.C. § 1002(1). At the time of the events giving rise to this lawsuit, the Plan provided, in relevant part:

> (t) Charges associated with organ transplants will be covered as follows:
>
> (I) The Plan will pay the regular portion of medically necessary reasonable and customary hospital and medical expenses related to the transplant of medically recognized human organ or tissue transplants from a living or cadaver donor to a transplant recipient.
>
> Transplants that are experimental/investigative as determined by the Plan Administrator are not covered.

(A.12).

The Plan was Shannon's secondary health benefits provider. Medicare was his primary source of health benefits coverage. Shannon has long-term diabetes mellitus Type I. As a result of his kidney failure, Shannon was advised by his treating nephrologist, Dr. David Hoffman, to undergo a kidney transplant. Shannon on his own

investigated the possibility of a simultaneous pancreas transplant and decided to have one done at the University of Minnesota, which agreed to perform the procedure (or at least to put Shannon on the cadaveric transplant list) if Shannon could come up with sufficient funding.

On August 16, 1990, Shannon, through the transplant surgeon at the University of Minnesota who would be performing Shannon's simultaneous kidney/pancreas transplant, at the University of Minnesota, initiated with the Plan on Shannon's behalf a request for pre-certification review and determination of benefits for the simultaneous kidney/pancreas transplant (App.1). The Plan considered Shannon's request in concert with a request for additional information from the surgeon, as well as input on the clinical efficacy of the procedure from its quality assurance/ utilization reviewer, Cost Care, Inc. CCI informed the Plan that pancreas transplants were medically investigational (App. 2-3). The Plan in turn informed Respondent that, while the Plan would cover expenses associated with the kidney transplant, it could not cover expenses associated with the pancreas transplant inasmuch as experimental or investigational procedures were excluded from Plan coverage (App. 3).

Thereafter, Shannon's surgeon sent an appeal to the Plan, enclosing medical journal articles on pancreas transplantation, which the Plan reviewed and sent on to Cost Care. CCI subsequently forwarded to the Plan its written medical opinion which stated that pancreas transplants were medically investigational and may well be considered "within the realm of experimental." (App.3).

The Plan Administrator additionally contacted another health insurance plan provider, and learned that it, too, considered pancreas transplantation to be experimental and not a covered procedure. The Administrator was also aware that Medicare was Shannon's primary health care benefits provider, and that Medicare refused to cover pancreas transplants because Medicare considered the technology experimental or investigational. (App. 2-3). Based upon CCI's medical analysis and recommendation that the pancreas transplant technology was clinically investigational, if not experimental; the

information which the Plan had received from the health carrier; and the knowledge that Medicare considered the procedure investigational or experimental, the Plan determined that the pancreas transplant was excluded from Plan coverage as investigational, and so notified Shannon (App. 3).

Shannon filed another appeal of the Plan's denial of the request for pre-authorization benefits for a pancreas transplant, but enclosed no new information. In response to the appeal, the Plan further investigated how other benefits administrators in the community dealt with pancreas transplants. Petitioner reaffirmed that the first benenfits provider which it had contacted did indeed consider pancreas transplant technology to be investigational and thus excluded from coverage. The Plan then contacted four additional health benefits providers, all of which stated that they considered the procedure to be experimental and not covered (with the exception of one which covered it "under some circumstances") (App.4). As a result, the Plan stood by its initial denial of Shannon's pre-certification request for benefits for the pancreas portion of his transplant. Respondent nevertheless underwent the pancreas/kidney transplant at his own cost, and the pancreas graft failed (App. 5).

The instant lawsuit followed. The United States District Court for the Southern District of Florida held that the Plan had acted arbitrarily and capriciously in making its coverage decision (App. 12, 15). The court remanded the matter back to the Plan for further consideration , with directions to "make a reasonable inquiry into all pertinent evidence available up to the date of [the decision on remand]." (App. 15, 17). The Plan took an appeal to the Eleventh Circuit, which was dismissed for want of jurisdiction, as the court held that the order of remand was not a final appealable order. *Jack Eckerd Corp. v.Shannon,* 55 F.2d 561 (11th Cir. 1995). In the meantime, the Plan did as the district court had instructed. As a result of evidence available at the time of the re-review, which was three (3) years after Respondent's request for benefits, the Plan determined that, ***under current standards***, the pancreas transplant was no longer medically experimental or investigational. The Plan noted that neither Respondent nor his physicians had submitted any new evidence as to the clinical efficacy of the procedure, but that its medical consultant

had stated that the *current* clinical data suggested the technology had advanced from the realm of experimental/investigational. Similarly, in checking with other health benefits providers which three (3) years before had refused to cover pancreas transplants because they considered the procedure experimental or investigational, the Plan learned that they, too, had begun to provide coverage for pancreas transplants ***under current standards***. Nevertheless, the Plan declined to pay Shannon any benefits because at the time he made his claim, the procedure was experimental/investigational, and thus not covered (App. 25). The district court ultimately entered a judgment on Respondent Shannon's behalf for the amount of the benefit, plus attorney's fees and costs, with pre-judgment interest (App. 19). The Eleventh Circuit affirmed (App. 20-23).

## REASONS FOR GRANTING THE PETITION

Even assuming *arguendo* that the Eleventh Circuit was correct in affirming the district court's finding that the Plan acted arbitrarily and capriciously in denying Respondent Shannon benefits for the pancreas transplant and remanding the matter to the Petitioner Plan for reconsideration, the appellate court nevertheless erred in affirming the district court's directions to the Plan to consider on remand evidence available after the date of the Plan's original coverage decision. The Eleventh Circuit's decision is squarely in conflict with the decisional law of the Eighth Circuit, notably the decisions in *Bernards v. United of Omaha Life Ins. Co.*, 987 F.2d 486 (1993) and *Cox v. Mid-America Dairymen, Inc.*, 965 F.2d 569 (8th Cir. 1992). In *Bernards*, the Eighth Circuit was confronted with an ERISA plan which had provided inadequate explanation for its coverage decision in a life and death matter. The court held that remand is the appropriate course of action when an ERISA plan's action lacks adequate explanation such that a reviewing court must seek fuller explanation before it can apply the deferential arbitrary and capricious standard of review. The Eighth Circuit's opinion makes clear, however, that the remand is to take place in the context of the evidence presented at the time of the request:

> To conduct meaningful review in these [emergency] circumstances, the district court must obtain from

> United a further explanation of its decision, afford Bernards the opportunity to present evidence challenging the decision..., and then apply the deferential standard of review to the expanded record.

987 F.2d at 488. Similarly, in another remand situation, the Eighth Circuit held:

> We have previously noted that, in order to properly apply the deferential standard of review, a reviewing court must be provided the rationale underlying the trustee's decision. [emphasis added].

*Cox v. Mid-America Dairymen, Inc.*, 965 F.2d 569, 573 (8th Cir. 1992). In *Cox*, the court was faced, as was the Eleventh Circuit in the instant case, with a situation where the plan did not adequately explain its canvasing and assessment of the evidence which it had before it. In neither *Cox* nor *Bernards* was the ERISA plan directed to consider evidence which may have developed in a lengthy period of time between the time of the participant or beneficiary's benefits claim and the time of remand. Rather, the Eighth Circuit's decisions make it clear that the remand is only for the purpose of the plan being able to better explain and, if need be, to reconsider the evidence that it had before it at the time it made its original decision.

The Eighth Circuit's approach is the correct one and represents the majority view of courts which have had occasion to reach this issue. This approach recognizes that medical science is a dynamic process, and what may be experimental today may be accepted therapy tomorrow. As the Northern District of Illinois held in *Estate of Goldstein v. Fortis Benefits Co.*, __F.Supp. __, 1996 WL 18977 (N.D. Ill. 1996):

> At some point, the body of scientific evidence gathered establishes that a procedure is or is not effective; at that point, it is presumably no longer experimental. Clinical research is ongoing and even the most tried and true procedures are constantly being re-evaluated. A line is eventually crossed,

> however, and a procedure becomes recognized and accepted within the medical community.

Accord: *Bushman v. State Mutual Life Assurance Co. of America*, 915 F.Supp. 945, 953-954 (N.D. Ill. 1996) ("Today's experiment may well be tomorrow's cure.")

Any reconsideration of the Petitioner Plan's benefits decision must therefore necessarily be restricted to evidence known at the time when the initial coverage decision was made. This is so because the state of the art of pancreas transplants when Respondent applied for pre-certification was all that the Plan had available to it for consideration. In order to provide meaningfully deferential review, therefore, the court could only request the Petitioner Plan to revisit and reconsider that evidence which it had available to it at the time it made its original coverage decision. *See, e.g., Nesseim v. Mail Handlers Benefit Plan*, 995 F.2d 804, 807 (8th Cir. 1993); *Holder v. Prudential Insurance Company of America*, 951 F.2d 89, 91 (5th Cir. 1992); *Denton v. First National Bank of Waco, Texas*, 765 F.2d 1295, 1304 (5th Cir. 1985). As the Fourth Circuit held in *Sheppard & Enoch Pratt Hosp. Inc. v. Travelers Ins. Co.*, 32 F.3d 120, 125 (4th Cir. 1994):

> We continue to adhere to the view expressed in Berry that an assessment of the reasonableness of the administrator's decision must be based on the facts known to it at the time. Thus, although it may be appropriate for a court conducting a *de novo* review of a plan administrator's action to consider evidence that was not taken into account by the administrator, the contrary approach should be followed when conducting a review under either an arbitrary and capricious standard or under the abuse of discretion standard.

Even the Eleventh Circuit has recognized the wisdom of this approach. *See, e.g., Jett v. Blue Cross and Blue Shield of Alabama, Inc.*, 890 F.2d 1137, 1140 (11th Cir. 1989).

This confinement of remand to consideration of evidence

available at the time when the coverage decision was first made is all the more appropriate when it is considered that Petitioner actually had the surgery in June 1991, and that it failed (App. 5). A remand that considers information available now (or even three (3) years after Shannon's request), but not available to the Plan administrator at the time her decision was made, unfairly burdens the Plan with the possibility of paying for a procedure which was investigational at the time it was requested and therefore excluded from coverage, but is no longer. The district court's decision, and the affirmance by the court of appeals, simply fails to account for the constantly changing nature of medical science.

The district court relied upon the District Court of Connecticut's decision in *Bucci v. Blue Cross/Blue Shield of Connecticut*, 764 F. Supp. 728, 732 (D. Conn. 1991) for its determination that the Plan must take account of after-acquired evidence in its decision on remand. The Eleventh Circuit concluded that the district court had acted reasonably in doing so (App. 23). However, the *Bucci* court was not dealing with a remand situation. Nor does the *Bucci* court cite any supporting authority for its conclusion that a benefits denial is continuing and must be measured by currently available information, even though a final determination has been made. Indeed, applying the *Bucci* court's reasoning to a remand situation such as the instant case clearly contravenes the pronouncement in *Bernards, Cox, Jett, Nesseim,Holder, Sheppard & Enoch Hosp.* and *Denton* that deference be afforded to plan administrators' decisions, rather than have such decisions imposed upon the plan by the federal courts. *Bernards v. United of Omaha Life Ins. Co.*, 987 F.2d 486 (1993); *See also, Cox v. Mid-America Dairymen, Inc.*, 965 F.2d 569 (8th Cir. 1992), (proper course is for court reviewing plan administrator's coverage decision under arbitrary and capricious standard to remand to plan administrator for explanation of why decision was made based on evidence before it at the time and then apply deferential standard to explanation); *Reilly v. Blue Cross and Blue Shield United of Wisconsin*, 846 F.2d 416, 427 (7th Cir. 1988) (Posner J. concurring and dissenting) (issue limited to deciding whether in vitro fertilization was still an experimental procedure at time claim was made); *Berry v. Ciba-Geigy Corporation*, 761 F.2d 1003, 1007 (4th Cir. 1985) (court may not put forth evidence that the plan administrator might have

considered but did not); *Esdale v. American Comm. Mutual Ins. Co.*, 914 F.Supp. 270 (N.D. Ill. 1996) (same). The Plan on remand in the instant case did exactly as the Eighth Circuit directed in *Bernards* and determined that, based on the evidence available at the time, its coverage decision was correct . However, in accordance with the district court's directive, the Plan went even further and acknowledged the progression of pancreas transplant technology from the realm of investigational to accepted therapy, *albeit three years after Shannon made his request.* The operative time frame, however, is not three years down the road; it is, as the courts have made clear, the time the original request was made. Therefore, the district court's directions on remand were clearly wrong as a matter of law. *Cf., Bechtold v. Physicians Health Plan of Northern Indiana, Inc.*, 19 F.3d 322 (7th Cir. 1993) (recommendations of change in plan coverage to keep up with pace of medical advances was beyond authority of reviewing medical committee). The Eleventh Circuit's affirmance of the district court was also legally in error.

## CONCLUSION

In light of the foregoing, Petitioner Jack Eckerd Corporation respectfully requests that this Honorable Court grant its petition for a writ of certiorari.

Respectfully submitted,
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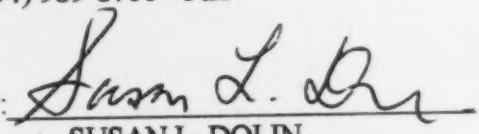
By: 
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APPENDIX
UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 91-0271-CIV-NESBITT

THOMAS SHANNON,

Plaintiff,

v.

JACK ECKERD CORPORATION,

Defendant

_____/

FINDINGS OF FACT
AND CONCLUSIONS OF LAW

This Cause was tried before this Court during the week of September 21, 1992. This is a lawsuit brought by Plaintiff Thomas Shannon ("Shannon") pursuant to the Employment Retirement Income Security Act ("ERISA"), 29 u.s.c. § 1132(A)(1)(b), to recover benefits for a simultaneous kidney/pancreas transplant performed in 1991 and a new pancreas transplant which has not yet been performed. Having carefully considered the evidence properly taken, the Court hereby makes the following findings of fact and conclusions of law:

FINDINGS OF FACT

In June, 1990, Shannon was diagnosed by Dr. David E.R. Sutherland, one of the leading authorities in the country on pancreas transplants, as suffering from renal disease secondary to diabetes. On behalf of Shannon, Dr. Sutherland sent a letter dated August 16, 1990 to Gail Azem--a Registered Nurse and Defendant Jack Eckerd Corporation's ("Eckerd") Health Claims Specialist--requesting that Eckerd issue prior authorization for benefits under the Jack Eckerd

Corporation Health Plan ("the Plan") for Shannon covering a combined kidney/pancreas transplant, all hospital and medical expenses required for the prescribed procedure, and future post-surgical benefits. Plaintiff's Exhibit 8.

In response to Dr. Sutherland's letter of August 16, 1990, Gail Azem advised Dr. Sutherland in a telephone conversation that took place sometime between August 16, 1990 and September 7, 1990 that Eckerd would pay for the kidney but not the pancreas transplant. Dr. Sutherland subsequently sent a letter dated September 7, 1990 to Gail Azem stating that he "would like to formally appeal the ruling in regard to the pancreas transplant..." Plaintiff's Exhibit 1. The letter indicated that, in Dr. Sutherland's experience, numerous insurance companies have provided coverage for pancreas transplants. Dr. Sutherland attached to the letter both a number of articles from the medical literature detailing the efficacy of pancreas transplants and a list of insurance companies that, in his experience, covered pancreas transplants and did not consider the procedure investigational. Eckerd treated the letter as a request for an explanation of a denial of benefits pursuant to Plan section 8.2.

Ms. Azem forwarded Dr. Sutherland's letter and attachments to Cost Care, Inc. ("Cost Care") for consideration. Cost Care is a medical review organization which employs physicians, nurses, and other health professionals to review the medical aspects of particular insurance claims. The Plan engaged Cost Care to render medical advice concerning benefits claims filed by Plan participants.

On September 21, 1990, Cost Care faxed to Eckerd its report concerning the medical status of pancreas transplants. At some time between September 7, 1990 and October 11, 1990, the Plan Administrator contacted Prudential Insurance Co. ("Prudential"), one of the companies on the list attached to the Sutherland letter of September 7, 1990, and inquired whether Prudential covered pancreas transplants. The Plan Administrator was informed that Prudential did not cover the transplants because the company considered the procedure to be investigational. The Plan Administrator, however, never inquired as to Prudential's definition of the term "investigational" or the criteria that Prudential used to determine that the pancreas transplant procedure met this definition.

The Plan Administrator, through Gail Azem, sent a letter dated October 11, 1990 to Dr. Sutherland explaining Eckerd's basis for denying Shannon's claim. Plaintiff's Exhibit 2. The letter closely parallels the report faxed by Cost Care to Eckerd on September 21, 1990 and indicates that Eckerd initially denied Shannon's claim for a pancreas transplant on the basis of medical evidence that the overall survival rate of patients who underwent combined kidney/pancreas transplants was comparable to that of patients who underwent only kidney transplants. The letter also states that this finding was based on data limited to one year post-transplant because data concerning survival rates at two to three years post-transplant was not provided. Finally, the letter points out that the American Medical Association ("AMA") and Medicare had not taken written positions with respect to whether pancreas transplants are experimental or investigational.

In response, Dr. Sutherland sent a letter dated October 27, 1990 to Eckerd requesting a formal appeal of Eckerd's decision to deny benefits regarding the pancreas transplant. Plaintiff's Exhibit 6. In this letter, Dr. sutherland provides significant additional information that undermines each of the bases given for the denial of Shannon's claim in the Azem letter of October 11, 1990. Dr. Sutherland writes that he did furnish Cost Care with data concerning survival rates at two and three years post-transplant and details the manner in which pancreas transplants affect improvements in the quality of life of diabetic patients. He also advises that, while Medicare had no written position regarding the [illegible]cal status of pancreas transplants, "Medicare has so uniform[illegible]overed renal transplant complications in pancreas recipients, [illegible]o deny the request for Mr. Shannon on this technicality indicates that the decision has been made on economic, and not on medical or quality of life issues". Finally, Dr. Sutherland cites statistical data supporting the position that the pancreas transplant procedure is well accepted and frequently performed.

The Plan Administrator's only response to Dr. Sutherland's letter was a letter dated December 10, 1990 to Lynn Shannon. The letter explained that Eckerd had received Dr. Sutherland's letter of October 27, 1990, that Eckerd was reviewing the information contained in the Sutherland letter, and that Eckerd would contact Shannon with a determination when the review was complete.

The Plan Administrator did not forward Dr. Sutherland's letter of October 27, 1990 to Cost Care for further review. Further, the Plan Administrator neither contacted Cost Care nor Dr. Sutherland at any time after receiving the October 27, 1990 letter to discuss any aspect of Shannon's claim, nor requested any further review by Cost Care or any other medical review organization. The Plan Administrator failed to take these steps even though she had earlier concluded that she was incapable of evaluating medical information regarding pancreas transplants and that a second consultation with a medial review organization was necessary. Although Dr. Sutherland's October 27, 1990 letter referred to Medicare's position regarding coverage for pancreas transplants, the Plan Administrator did not contact anyone at Medicare to inquire about Medicare's position concerning coverage of the procedure.

After receiving the letter, the plan Administrator did contact five insurance companies listed on an attachment to the Sutherland letter of September 7, 1990 and inquired whether these companies covered pancreas transplants. Four of these companies informed the Plan Administrator that they did not cover the procedure because they considered it to be "investigational". The Plan Administrator testified that she accepted the companies' definition of the term "investigational" without any inquiry as to the criteria used to determine that the pancreas transplant procedure met this definition. The day after the Plan Administrator sent her letter of December 10, 1992, she received a letter fax from Traveler's Insurance Co. ("Traveler's")--the fifth insurance company that she contacted. The fax sets out medical criteria governing a patient's suitability for a pancreas transplant. The Plan Administrator never contacted Traveler's to determine how the company used the information and never forwarded the information to Cost Care.

The Plan Administrator failed to inform either Shannon or Dr. Sutherland of her decision concerning Shannon's appeal[1]. The

---

[1] This failure constitutes a violation of Plan section 8.3, which requires the Plan Administrator to communicate in writing his or her resolution of a claims appeal within sixty (60) days after receiving the document initiating the appeal.

Plan Administrator's ultimate decision to deny Shannon's claim occurred on December 28, 1990 by operation of law[2].

Following this denial, Shannon underwent a combined kidney/pancreas transplant operation in 1991. The kidney transplant was successful. Shannon's system, however, rejected the pancreas, necessitating a second pancreas transplant. To date, Shannon has not undergone the second pancreas transplant procedure. Shannon never communicated his need for second pancreas transplant to Eckerd except through this litigation.

The facts summarized above create the following issues:

I. Did Shannon properly file a claim within the meaning of the Plan with respect to either the combined kidney/pancreas procedure requested in 1990 or the second pancreas transplant procedure necessitated by the rejection of the first pancreas?

II. Did Shannon properly file an appeal of the denial of his claim for coverage of the combined kidney/pancreas transplant procedure?

III. Was the Plan Administrator's ultimate denial of Shannon's claim for coverage of the kidney/pancreas transplant procedure arbitrary and capricious?

CONCLUSIONS OF LAW

I. Filing

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[2] 29 C.F.R. 2560.503-1 provides that, absent special circumstances, if the decision on review of a denial of a claim has not been issued within sixty days after the date on which the document initiating review was filed, the claim shall be deemed denied on review. As noted earlier, Dr. Sutherland's letter of October 27, 1990 represents the document initiating review in the present case. As of December 27, 1990, the sixtieth day after the Sutherland letter was sent to Eckerd, Eckerd had not responded to the letter. Accordingly, Shannon's claim was deemed denied on review on December 28, 1990 pursuant to 29 C.F.R. 2560.503-1.

(i) Shannon filed a claim for coverage of a combined kidney/pancreas procedure

Shannon cannot recover benefits for the cost of a combined kidney/pancreas transplant unless he properly filed a claim for these benefits under the Plan. In order to determine whether Shannon properly filed a claim for these benefits, the Court must determine weather he had a standing to file a claim within the meaning of the Plan. Further, since Shannon communicated with Eckerd through Dr. Sutherland, the Court must determine whether Dr. Sutherland had standing to file a claim under the Plan on Shannon's behalf. Finally, the Court must determine whether Shannon's failure to file a claim form renders his claim invalid.

The Court finds that Shannon had standing to file a claim under the Plan. Section 8 of the Plan limits the availability of the claims procedure to "Participants" in the Plan. Plan section 2.26 defines "Participant" as, among other things, a "Dependent who is eligible for coverage and who is in fact covered for benefits under this Plan in accordance with Articles III and IV of this Plan Document". Pursuant to Plan section 2.6, the term "Dependent" includes the spouse of an Eckerd employee. It is not disputed that Shannon's wife was an Eckerd employee at all times material to this cause. Shannon was therefore a Dependent within the meaning of the Plan at all times material to this cause. In addition, at all times material to this cause, Shannon was eligible for coverage under Articles III and IV of the Plan and was in fact covered under those articles. Accordingly, the Court concludes Shannon satisfied all conditions necessary to qualify as a Participant under the Plan.

The Court also concludes that Dr. Sutherland had standing to file a claim on Shannon's behalf. Plan sections 8.2 and 8.3 require that the claims review and appeals procedures be initiated by a Participant. It cannot be reasonably disputed that physicians often assist their patients in the preparation of health insurance claims.[3] As

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[3] E. Haavi Morreim, Gaming the System: Dodging the Rules, Ruling the Dodgers, 151 Arch. Intern. Med. 443-447 (March, 1991) ("Today, the patient commonly, and necessarily, enlists the

this is a widespread practice, the Court finds that the term "Participant", as used in Plan sections 8.2 and 8.3, refers to both participants and physicians acting on their behalf.

At the very least, the regularity with which physicians act on behalf of their patients creates an ambiguity as to the scope of the term "Participant". This ambiguity, in conjunction with Eckerd's conduct, enables the Court to apply the doctrine of equitable estoppel to preclude Eckerd from denying that Dr. Sutherland had standing to file a claim on Shannon's behalf. Since ERISA preempts the application of state law with respect to the interpretation of ERISA-covered plans, the doctrine has its source in federal common law.

The doctrine contains three requirements. These requirements include: (1) an intentional deception through concealment or inaction, or gross negligence amounting to a constructive fraud, (2) justifiable reliance, and (3) damages. Zittrouer v. Uarco, Inc. Group Ben. Plan, 582 F.Supp. 1471 (N.D. Ga. 1984)[4].

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aid of his or her physician in preparing claims for health and disability. Such forms ordinarily require information possessed solely by the treating physician as well as the physician's signature attesting to the bona fides of that medical information").

[4] The traditional formulation of the test concerning equitable estoppel requires the party asserting estoppel prove that the party against whom the doctrine is asserted misrepresented a material fact. See Nat'l Companies Health P., 929 F.2d at 1572. The Eleventh Circuit has held, however, that the formulation of the test articulated above is equivalent to the traditional formulation. In Nat'l Companies Health P., the court stated that:

> There are several different ways to recapitulate the elements of the federal common-law claim of equitable estoppel . . . . The Zittrouer test . . . is simply a reformulation of traditional estoppel principles, and is used for estoppel claims involving material omissions rather than misrepresentations; any difference between this test and the district court's (and our) test is

The Court finds that each of these elements is met here. There is no evidence that anyone at Eckerd ever informed either Dr. Sutherland or Shannon that Dr. Sutherland was not entitled to file a claim on Shannon's behalf. On the contrary, all of the communications made by Eckerd to Dr. Sutherland suggest that Eckerd treated the Sutherland letter of August 16, 1990 as a claim. Eckerd responded to the letter by telephonically advising Dr. Sutherland that the claim was denied. When Dr. Sutherland twice attempted to appeal the claim, Eckerd responded to the first attempt with a letter explaining the basis of its denial and to the second with a letter advising Dr. Sutherland that Eckerd was reviewing its denial. On the basis of this conduct, the Court finds that, if the term "participant" excludes a physician acting on a participant's behalf, then Eckerd either intentionally concealed this fact from Shannon or was grossly negligent in failing to inform him of this fact.

Moreover, it is clear that Shannon relied on his belief that Dr. Sutherland had standing to file a claim on his behalf. Shannon has taken an active interest in his medical condition for some time. The Court is convinced that, had Eckerd explained to either Shannon or Dr. Sutherland that Dr. Sutherland was not entitled to file a claim on Shannon's behalf, Shannon would have filed a claim personally. In view of the fact that physicians often assist plan participants with the filing of claims, the Court concludes that Shannon's reliance was justifiable. Finally, it is clear that Shannon would suffer damages if the Court were to decline to enforce coverage based on this reliance. As a consequence, all of the elements of equitable estoppel are met. Accordingly, the Court finds that Eckerd is estopped from denying that Dr. Sutherland's letter was sufficient to file a claim within the meaning of the Plan.

Finally, the Court finds that Shannon's failure to file a claim form does not invalidate his claim. Plan section 8.1 provides, among other things, that a claim form is required "for each Participant's separate Illness or Injury". According to Plan section 2.17, the term "Illness" refers to "sickness or disease which causes interruption,

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insignificant.
929 F.2d at 1572-1573.

cessation, or disorder of body functions, systems or organs, and which requires treatment by a Physician". Under this definition, Shannon's condition clearly constitutes an illness within the meaning of the Plan. It would therefore appear that Shannon was required to file a claim form in order to file a proper claim.

A close examination of the language in Plan section 8.2, however, belies this conclusion. Section 8.2 provides in pertinent part:

> Any Participant or former Participant, who wishes to request an informal review of a claim for benefits or who wishes an explanation of a benefit or its denial, must direct written request to the applicable Plan Administrator for an informal review. (Emphasis added).

The use of the underlined disjunctive indicates that an informal review of benefits is distinct from an explanation of a denial. The Court concludes that an "informal review of a claim for benefits" does not refer to a review of the denial of a claim, but rather refers to the initial review of the claim. There is no indication from the language of section 8.2 that a claim form is required to initiate such review. Rather, this review can only be initiated by the filing of a written request[5].

Even if Shannon had been required to file a claim form, the Court finds that Eckerd is estopped from asserting that Shannon's failure to file a claim form disqualifies his claim. Eckerd never informed either Dr. Sutherland or Shannon that a claim form was required to file a proper claim and at all times dealt with Dr. Sutherland as if Shannon had filed a proper claim. As a consequence,

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[5] Section 8.2 also provides, in subsection c, that the response issued pursuant to this request describes any material necessary to perfect the claim. This material would reasonably include a claim form if one had not been filed previously. The Court concludes that a claim form is not required in order to file a claim, merely to perfect a claim.

the Court finds that Eckerd either intentionally concealed the claim form requirement or negligently failed to apprise Shannon of the requirement. The Court also finds that Shannon relied on his belief that no such requirement existed and that Shannon would lose coverage if his failure to comply with the requirement were found to preclude coverage of the pancreas transplant procedure. Accordingly, Eckerd's conduct satisfies all of the elements of equitable estoppel.

Based on the foregoing, the Court finds that Shannon's failure to file a claim form does not invalidate his claim for benefits covering a combined kidney/pancreas transplant. The Court also finds that Dr. Sutherland's letter of August 16, 1990, which requests prior authorization for these benefits, represents the written request necessary to initiate a claim. The Court concludes that Shannon properly filed a claim for these benefits under the terms of the Plan.

(ii) Shannon did not file a claim for a second pancreas transplant.

The case law interpreting ERISA provides that a plan beneficiary or participant must exhaust his or her administrative remedies before ringing suit in federal district court pursuant to 29 U.S.C. § 1132(a)(1)(B). See, e.g. DePina v. General Dynamics, 674 F. Supp. 46 (D. Mass. 1987) (holding that requirement of exhaustion of administrative remedies applies to disputes involving ERISA plan benefits); see also, Amato v. Bernard, 618 F. 2d 559 (9th Cir. 1980). In the present case, however, there is no evidence in the trial record indicating that Shannon ever filed a claim for the pancreas transplant procedure necessitated by his body's rejection of the pancreas introduced in the combined kidney/pancreas transplant that he underwent in 1991. Accordingly, the Court finds that his suit to clarify the terms of the Plan and to enforce his alleged right benefits for a second pancreas transplant is premature.

II. Appeal

Under Plan section 8.3, Shannon properly filed an appeal of the denial of his claim for benefits covering a combined kidney/pancreas transplant

Plan section 8.3 permits a participant to appeal a claim for benefits that is wholly or partially denied. The section does not require that a claim be perfected in order to be appealable. Thus, the Court finds that Shannon's failure to file a claim form does not disqualify his appeal under this section. Even if a claim form were required, Eckerd's letter of December 10, 1990 indicates that Eckerd treated the Sutherland as an appeal. Accordingly, Eckerd is equitably estopped from asserting that Shannon's failure to file a claim form precluded appeal from the denial of his claim. See analysis supra.

III. Propriety of the Plan Administrator's Decision

The Plan Administrator's ultimate decision to deny Shannon benefits for a combined kidney/pancreas transplant was arbitrary and capricious.

The Plan Administrator's decision to deny benefits to Shannon is reviewable pursuant to the arbitrary and capricious standard of review. Under that standard, the Court must determine whether there was a reasonable basis for the Plan Administrator's decision. Jett v. Blue Cross and Blue Shield of Alabama, 890 F. 2d 1137, 1139 (11th Cir. 1989). In order to make that determination, the Court must make two findings. First, the Court must find that the Plan Administrator gathered facts sufficient to serve as the basis on which a reasonable decision might have been rendered. See Motor Vehicle Mfr. v. State Farm Mut., 103 S.Ct. 2856, 2866 (1983) (requiring that a decisionmaker subject to review under the arbitrary and capricious standard "examine the relevant data and articulate a satisfactory explanation for its actions"); Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534 (9th Cir. 1990) (upholding district court's finding that evidence gathered by an ERISA administrator provided an altogether inadequate basis for administrator's denial of benefits under group health and medical policy and therefore that denial was arbitrary and capricious). Second, the Court must find that the Plan Administrator rendered a reasonable decision after these facts. See Jett, 890 F. 2d at 1139.

The Plan Administrator's decision was based on Plan section 5.8(t)(i), which became effective on June 1, 1990 and which defined the Plan's coverage with respect to organ transplants. The section

provided that:

> (t) Charges associated with organ transplants will be covered as follows:
>
> (i) The Plan will pay the regular portion of medically necessary reasonable and customary hospital and medical expenses related to the transplant of medically recognized human organ or tissue transplants from a cadaver donor to a transplant recipient.
>
> Transplants that are experimental/ investigative as determined by the Plan Administrator are not covered.

The Plan contained no definition of these terms "experimental" or "investigative". The conduct of the Plan Administrator between August 16, 1990--the date on which Shannon's claim was first filed--and December 27, 1990--the date on which Shannon's claim was ultimately denied--is relevant to the reasonableness of the Plan Administrator's decision.

The Court finds that the Plan Administrator's failure to inform Shannon of her ultimate decision regarding the appeal of his claim was not arbitrary and capricious. See Newell v. Prudential Ins. Co. Of America, 725 F. Supp. 1233, 1239 (N.D. Ga. 1989) (holding that the failure of an administrator of employee welfare benefit plan and/or its preadmission and concurrent review service to meet its self-imposed standard for affording oral and written notice to hospital, patient, and physician concerning precertified authorization was not arbitrary or capricious).

The Court also finds, however, that the Plan Administrator failed to gather facts sufficient to establish a reasonable basis for denying Shannon's claim. The Plan Administrator testified that she based her ultimate decision to deny Shannon's claim on the following three criteria: (i) the fact that Medicare denied payment for Shannon's claim, (ii) the fact that Cost Care advised her that the pancreas

transplant procedure was regarded as investigational by the medical community, and (iii) the fact that a number of insurance companies classified the procedure as investigational.

The Plan Administrator, however, failed to adequately investigate any of these criteria. Although the Plan Administrator claims to have known that Medicare denied Shannon's claim, there is no evidence that she was aware of the basis for this denial. Medicare might have denied the claim based on criteria unrelated to whether the procedure was investigational. Medicare, for instance, might have declined coverage for pancreas transplants for economic reasons. If this had been the case, Medicare's decision to deny Shannon benefits would have no bearing on whether the pancreas transplant procedure is investigational. In addition, the Plan Administrator knew that Medicare had no formal position in writing concerning whether the procedure was experimental or investigational and learned from Dr. Sutherland that Medicare had often covered procedures related to renal transplant complications in the past. Under these circumstances, the Plan Administrator's failure to make further inquiry into Medicare's position on the status of the pancreas transplant procedure renders any reliance on the fact that Medicare denied Shannon's claim unreasonable.

The Plan Administrator also failed to adequately investigate the medical status of the pancreas transplant procedure. After receiving Dr. Sutherland's letter of October 27, 1990, the Plan Administrator had notice that Cost Care's conclusion that the procedure was investigational may have been made without all of the data relevant to survival rates post-transplant and without any consideration for quality of life improvements associated with the procedure. Despite this notice, the Plan Administrator did nothing to ensure a more thorough evaluation. The Plan Administrator did not engage another medical consultant for a second evaluation, despite her conclusion that a second evaluation was necessary. She did not contact Dr. Sutherland--one of the country's leading authorities on the procedure and Shannon's treating physician--for further explanation of his criticisms of Cost Care's evaluation. She did not request that Cost Care review its conclusion nor demand that Cost Care issue a more complete explanation of the basis for its conclusion. In fact, the Plan Administrator did not even contact Cost Care to apprise Cost

Care of the new information that she had received. The Plan Administrator failed to take any of these actions despite her admitted inability to comprehend either the substance or significance of information related to the medical status of the pancreas transplant procedure. The Court concludes that the Plan Administrator simply ignored the information the Sutherland letter of October 27, 1990 criticizing Cost Care's evaluation. Under these circumstances, the Court finds that any reliance that the Plan Administrator placed on Cost Care's evaluation was unreasonable. See White v. Caterpillar, 765 F. Supp. 1418 (W.D. Mo. 1991) (holding that the termination by the administrator of an ERISA plan that autologous bone marrow transplantation procedure was an "investigational" treatment was arbitrary and capricious in light of a recent study which should have put the administrator on notice that the efficacy of the procedure was at least debatable, so that further examination would have been prudent).

The only other basis for the Plan Administrator's decision was that four out of the five insurance companies that she contacted classified the pancreas transplant procedure as investigational. The Court concedes that the Plan Administrator might have based her interpretation of the term "investigational" on a consensus within the insurance industry as to the meaning of the term. The Court finds, however, that the Plan Administrator's investigation was insufficient to determine whether such a consensus existed. The Plan Administrator had Dr. Sutherland's list of more than fifty insurance companies which had, in Dr. Sutherland's experience, covered the pancreas transplant procedure. She made no independent effort to determine how many other insurance companies had taken positions with respect to coverage for pancreas transplants or to determine what number of insurance companies would have furnished a reliable representation of the industry's view on the subject. Instead, she contacted only five of the companies on Dr. Sutherland's list and never inquired as to the manner in which any of these companies defined the term "investigational". Although four out of the five companies that she contacted classified the pancreas transplant procedure as "investigational", the criteria that these insurers used to make this classification may have been radically different. The insurers may thus have reached very different conclusions about the procedure. As a consequence, the fact that four insurers

characterized the procedure as "investigational" was insufficient to reveal any real consensus as to the meaning of that term within the industry.

## CONCLUSION

Based on the foregoing findings of fact and conclusions of law, the Court concludes that, under the terms of the Plan, Shannon properly filed a claim for a combined kidney/pancreas transplant and properly took an appeal from the denial of that claim. The Court further concludes that the Plan Administrator's decision to deny benefits for this claim was arbitrary and capricious. This conclusion, however, does not authorize the Court to award Shannon benefits for the combined kidney/pancreas transplant that he underwent in 1991. Where the Court determines that a plan administrator's decision concerning a benefits claim was arbitrary and capricious because the plan administrator failed together sufficient evidence upon which a reasonable decision might have been based, the Court must remand the matter to the plan administrator for a new determination. Jett, 890 F. 2d at 1140 ("'As a general matter a court should not resolve the eligibility question on the basis of evidence never presented to [an ERISA plan's administrator] but should remand to the [administrator] for a new determination'") quoting Wardle v. Central States, Southeast and Southwest Areas Pension Funds, 627 F. 2d 820, 824 (7th Cir. 1980); Berry v. Ciba-Geigy Corp., 761 F.2d 1003 (4th Cir. 1985) ("If the court believed the administrator lacked adequate evidence, the proper course was to 'remand to the trustees for a new determination' . . . "). The Plan Administrator's failure to consider all of the relevant evidence available at the time she made her determination renders that determination arbitrary and capricious. As a consequence, the Court must remand the matter to the Plan Administrator for a new determination.[6]

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[6] The Court notes that the Plan Administrator's new determination must be made after a reasonable inquiry into all relevant evidence available up to the date of the new determination. See Bucci v. Blue Cross-Blue Shield of Conn., 764 F. Supp. 728 (D. Conn. 1991) ("[D]efendant's duty to provide benefits is a continuing one, its refusal to provide benefits is thus a continuing

In the Amended Complaint, Shannon also sought to "clarify his right" to future benefits covering a second pancreas transplant. Shannon, however, did not present any evidence that he filed a claim with Eckerd for benefits covering a second pancreas transplant or for other "future benefits". As a consequence, Shannon has not exhausted his administrative remedies under the Plan concerning his request for a declaration of his right to future benefits and the Court cannot therefore grant such relief at this time.

DONE AND ORDERED in chambers, Miami, Florida, this 18th day of November, 1992.

LENORE C. NESBITT
UNITED STATES
DISTRICT JUDGE

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denial, the propriety of which is measured against the information available from time to time.").

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 91-0271-CIV-NESBITT

THOMAS SHANNON,

Plaintiff,

v.

JACK ECKERD CORPORATION,

Defendant

FINAL JUDGMENT

For the reasons stated in the Order Granting Plaintiff's Motion for Entry of Final Judgment entered on the date hereof, it is thereupon

ORDERED AND ADJUDGED that the judgment be entered in favor of Plaintiff Thomas Shannon and against Defendant Jack Eckerd Corporation in the amount of $70,714.35 plus pre-judgment interest, costs, and attorney's fees.

DONE AND ORDERED in Chambers at Miami, Florida, this 31st day of October, 1995.

LENORE NESBITT
U.S. DISTRICT JUDGE

Thomas SHANNON, Plaintiff-Appellee,

v.

JACK ECKERD CORPORATION, a
Delaware Corporation, Defendant-
Third Party Plaintiff-Appellant,

Cost Care, Inc., a California Corporation,
Third-Party Defendant.

No. 96-4291

United States Court of Appeals,
Eleventh Circuit

May 29, 1997

Employee insured under Employee Retirement Income Security Act (ERISA) plan filed action against plan administrator, alleging that administrator acted arbitrarily and capriciously in denying him coverage for pancreas transplant. The United States District Court for the Southern District of Florida, No. 910271-CIV-LCN, Lenore Carrero Nesbitt, J., remanded matter to administrator. Administrator appealed. The Court of Appeals, 55 F.3d 561, dismissed appeal. On remand, plan administrator determined that pancreas operation was covered under current standards, but refused to pay any benefits on basis that procedure was investigational at time claim was made. The District Court, No. 91-0271-CIV-NESBITT, entered final judgment for amount of benefits. Administrator appealed. The Court of Appeals, Barkett, Circuit Judge, held that district court did not err in directing plan administrator to consider all relevant evidence on remand, and under that standard propriety of denial was to be measured against information available at time of reconsideration.

Affirmed.

Appeal from the United States District Court for the Southern District

of Florida.

Before HATCHETT, Chief Judge, BARKETT, Circuit Judge, and RONEY, Senior Circuit Judge:

Thomas Shannon filed this action after Jack Eckerd Corporation denied his request for preauthorization of benefits under an employee group health plan. Eckerd is appealing the district court's judgment awarding Shannon $70,714.35. Eckerd argues on appeal that the district court erred in denying its motion for summary judgment and in finding that the Plan's original denial of benefits was arbitrary and capricious. Eckerd also contends that the district court erred in directing the Plan administrator on remand to consider evidence available subsequent to the denial determination.

Thomas Shannon is a beneficiary under the Jack Eckerd Corporation Health Benefits Plan ("the Plan"), a self-funded plan governed by the Employee Retirement Income Security Act ("ERISA"). Shannon suffers from long-term diabetes mellitus Type I, which has resulted in severe renal disease and kidney failure. Due to these complications, Shannon's doctor advised Shannon to undergo a kidney transplant. After further consultation with other physicians, Shannon decided to undergo a simultaneous kidney/pancreas transplant at the University of Minnesota. The University of Minnesota requires either advance payment or verification of insurance coverage before a patient can be placed on the cadaveric pancreas transplant list. Accordingly, Shannon's surgeon requested preauthorization of benefits for the procedure from the Plan. At the time Shannon sought benefits for his transplant, the Plan excluded coverage for experimental or investigational human organ transplants. The Plan administrator rejected the claim for those benefits, informing Shannon and his surgeon that although the Plan would cover expenses associated with the kidney transplant, it could not cover expenses associated with the pancreas transplant because it was medically experimental or investigational and the Plan excluded coverage for experimental or investigational human organ transplants. Shannon's surgeon filed a formal appeal but the Plan administrator continued to deny coverage for the pancreas portion of the transplant. Shannon went forward with the transplant using other funding, but the pancreas graft failed. Shannon then sued under

ERISA, 29 U.S.C. § 1132(a)(1)(B)[7] to recover the benefits denied by the Plan administrator. After a bench trial, the district court found that in rejecting the claim as investigational, the Plan administrator had failed to consider all of the relevant evidence available and concluded that this failure rendered the Plan administrator's denial of benefits for the pancreas portion of the transplant arbitrary and capricious. The district court remanded the matter to the Plan administrator for a new determination based upon all relevant evidence including subsequently available evidence.[8] On remand, the Plan administrator determined that the pancreas operation was covered under current standards. However, the Plan refused to pay Shannon any benefits, arguing that at the time Shannon made his claim the procedure was experimental/investigational. Shannon again sought relief in the district court and the district court entered final judgment for the benefits in accordance with the Plan administrator's conclusion that the pancreas procedure was covered.

[1-3] We review a district court's grant of summary judgment *de novo* applying the same legal standards that control the district court's determination. *Jones v. Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S.Ct. 948, 956, 103 L.Ed 80 (1989); *Jett v. Blue Cross and Blue Shield of Alabama, Inc.*, 890 F.2d 1137, 1138-1139 (11th Cir. 1989); There is no dispute that the Eckerd Plan gives its administrator discretionary authority to determine eligibility for benefits. Therefore, we must determine whether the Plan administrator's decision was arbitrary and capricious. *Jett*, 890 F.2d at 1139. A decision to deny benefits is arbitrary and capricious if no reasonable basis exists for the decision. *Id.* In this case the district court found that in evaluating whether the proposed procedure was

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[7] "A civil action may be brought by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C.A. § 1132(a)(1)(B) (West 1985).

[8] Eckerd's appeal to this Court of the remand order was dismissed for want of jurisdiction.

experimental or investigational, the Plan administrator relied only on Medicare's denial of coverage, a conclusory recommendation of denial from Cost Care, the Plan's medical consultant, and the statements of several insurance companies that pancreas transplants were "investigational". The court concluded that this was an insufficient basis to support the denial. Simply accepting the bald assertion of Cost Care and the denial of other insurance companies without examining or evaluating their underlying bases and falling to obtain additional relevant information was arbitrary and capricious. We cannot say that the district court erred in remanding for the Plan administrator to make a reasonably relevant inquiry.

[4] Nor can we say that the district court erred in directing the Plan administrator to consider subsequently available evidence. The district court relied on *Buddi v. Blue Cross-Blue Shield of Conn.*, 764 F.Supp. 728, 732 (D.Conn. 1991), holding that since a defendant's duty to provide benefits "is a continuing one, its refusal to provide benefits is thus a continuing denial, the propriety of which is measured against the information available from time to time." Eckerd's Plan administrator had an obligation to make a reasonably relevant inquiry and failed to do so at the time of the original determination. The district court did not err in directing that the Plan administrator consider all available evidence. As we stated in *Jett*, "Should [the beneficiary] wish to present additional information that might affect the determination of eligibility for benefits, the proper course would be to remand to [the plan administrator] for a new determination." 890 F.2d at 1140. Accordingly, we AFFIRM.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 91-0271-CIV-NESBITT

THOMAS SHANNON,

Plaintiff-Appellee,

v.

JACK ECKERD CORPORATION,
a Delaware corporation,

Defendant-Third Party
Plaintiff-Appellant,

COST CARE, INC., a
California corporation,

Third Party Defendant.

On Appeal from the United States District Court
for the Southern District of Florida

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ON PETITION(S) FOR REHEARING AND SUGGESTION(S) OF REHEARING EN BANC

Before: HATCHETT, Chief Judge, BARKETT, Circuit Judge, and RONEY, Senior Circuit Judge.

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no member of this panel nor other Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 35-5), the Suggestion(s) of Rehearing En Banc are DENIED.

jack eckerd corporation

August 31, 1993

Mr. Thomas Shannon

Dear Mr. Shannon:

This is a redetermination of your claim for a combined pancreas/kidney transplant made on August 16, 1990 pursuant to the Jack Eckerd Corporation Employee Health Benefits Plan. As you are aware, the Plan has always maintained that the renal portion of the procedure was a covered expense, but that the pancreas portion of the procedure was not a covered expense because it was considered to be an investigational procedure. The Plan stands by their original determination, and has made this redetermination only because it has been ordered to do so by the United States District Court for the Southern District of Florida in Case No. 91-0271-CIV- Nesbitt/Bandstra. It is further to be noted that the matter is currently on appeal before the United States Court of Appeals for the Eleventh Circuit, and that the Plan reserves all appellate rights. Therefore, this redetermination is not to be considered in any fashion as a waiver of the Plan's appellate rights.

In addition, in accordance with the Court's order, the Plan has made its redetermination based on current information and standards. Again, the Plan does not concede that current standards apply, and in fact maintains that this is an issue to be decided by the United States Court of Appeals for the Eleventh Circuit. Therefore, the fact the Plan made the redetermination contained herein in accordance with current standards is not to be construed as a waiver of any of its appellate rights.

It must first be noted that neither you nor Dr. Thomas Sutherland, your treating physician and the person most active in pursuing this claim on your behalf, submitted any additional information to the Plan to be considered. Accordingly, the Plan undertook its own research to make the redetermination in accordance with the Court's order.

The Plan's utilization review physician who acts as consultant to the Plan is of the belief that, <u>under current standards</u> a pancreas transplant is no longer considered experimental or investigational. Therefore, the currently available clinical data suggests that, at least in the medical sense, this procedure is no longer considered to be investigational.

BEST AVAILABLE COPY

Medicare, your primary health insurer, still will not cover pancreatic transplant because it considers the procedure to be investigational and/or experimental. However, Medicaid of Florida does cover the procedure. Of the insurance companies which we were able to contact, approximately 80%, under current standards, consider the procedure to be non-experimental and/or non-investigational, and of those insurers which do not specifically exclude pancreatic transplant will cover the procedure. Significantly, the companies which now consider, under current standards, the procedure to be covered include Aetna, John Hancock, and Prudential, all of which refused to cover the procedure at the time your claim was first made, on the grounds that it was experimental or investigational.

In light of the foregoing, the Plan has concluded that, under current standards, the pancreas transplant is currently considered neither experimental nor investigational, and would be covered under Article V, Section 5.8(t) of the Plan document amendments effective June 1, 1990, which governed your claim.

Respectfully,

(Deloris Nelms)

Deloris Nelms
Manager, Health Claims